

415.414: Utilization Review

(A) All inpatient services must be provided in accordance with 130 CMR 450.204 or 130 CMR 415.415, and are subject, among other things, to utilization review under 130 CMR 450.207 through 130 CMR 450.211 and to requirements governing overpayments under 130 CMR 450.235(B) and 450.237.

(B) (1) The Division (or its agent) will review inpatient services provided to members to determine the medical necessity, pursuant to 130 CMR 450.204, or administrative necessity and appropriateness, pursuant to 130 CMR 415.415, of such services. Any such review may be conducted prior to, concurrently, or retrospectively following the member's inpatient admission. Reviewers consider the medical-record documentation of clinical information available to the admitting provider at the time the decision to admit was made. Reviewers do not deny admissions based on what happened to the member after the admission. However, if an admission was not medically necessary at the time of the decision to admit, but the medical record indicates that an inpatient admission later became medically necessary, the admission will be approved as long as all other Division requirements are met. (2) If, pursuant to any review, the Division concludes that the inpatient admission was not medically or administratively necessary, the Division will deny payment for the inpatient admission.

(3) If the Division issues a denial notice for an acute inpatient hospital admission pursuant to 130 CMR 415.414 and 450.204 as well as either 450.211 or 450.237, the hospital may rebill the claim as an outpatient service, as long as the Division has determined the service would have been appropriately provided in an outpatient setting. In order for the hospital to receive payment under 130 CMR 415.414(B)(3), the outpatient claim and a copy of the denial notice must be received by the Division within 90 days from the date of the denial notice and must comply with all applicable Division requirements.

(C) To support the medical necessity of an inpatient admission, the provider must adequately document in the member's medical record that a provider with applicable expertise expressly determined that the member required services involving a greater intensity of care than could be provided safely and effectively in an outpatient setting. Such a determination may take into account the amount of time the member is expected to require inpatient services, but must not be based solely on this factor. The decision to admit is a medical determination that is based on factors, including but not limited to the:

- (1) member's medical history;
- (2) member's current medical needs;
- (3) severity of the signs and symptoms exhibited by the member;
- (4) medical predictability of an adverse clinical event occurring with the member;
- (5) results of outpatient diagnostic studies;
- (6) types of facilities available to inpatients and outpatients; and
- (7) Division's Acute Inpatient Hospital Admission Guidelines in Appendix F of the *Acute Inpatient Hospital Manual* and in various appendices of other appropriate provider manuals. The Division has developed such guidelines to help providers determine the medical necessity of an acute inpatient hospital admission. These guidelines indicate when there is generally no medical need for such an admission.

(D) If, as the result of any review, the Division determines that any hospital inpatient admission, stay, or service provided to a member was not covered under the member's coverage type (see 130 CMR 450.105) or was delivered without obtaining a required authorization including, where applicable, authorization from the member's primary-care provider, the Division will not pay for that inpatient admission, stay, or service.

415.415: Reimbursable Administrative Days

(A) Administrative days as defined in 130 CMR 415.402 are reimbursable if the following conditions are met:

- (1) the recipient requires an admission to a hospital or a continued stay in a hospital for reasons other than the need for services that can only be provided in an acute inpatient hospital as defined in 130 CMR 415.402 (see 130 CMR 415.415(B) for examples); and

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2. The admission occurs when the member's condition had improved significantly in response to outpatient treatment with a progression toward either normal clinical parameters or the member's baseline.
3. The admission is for further monitoring or observing for potential complications when the member undergoes a procedure that is appropriately performed in an outpatient setting according to the current standards of care, the procedure is performed without complications, and the member's clinical status is approaching either normal clinical parameters or his or her baseline.
4. The admission is primarily for providing or monitoring the services and treatment of a member with multiple or complex medical needs whose needs were adequately being met in a setting other than an acute inpatient hospital prior to that admission.
5. The admission of a member whose baseline clinical status is outside of the normal clinical parameters and whose condition has been managed successfully on an outpatient basis, when the admission is based primarily on the member's abnormal status, unless that status has significantly deteriorated.
6. The admission is primarily to observe for the possible progression of labor when examination and monitoring does not indicate definite progression of active labor leading to delivery.
7. The admission is primarily for education, teaching, minor medication changes and/or monitoring, or adjustment of therapies associated with a medically stable condition(s).
8. The admission is primarily because the member requires sedation or anesthesia in order to conduct diagnostic tests that are appropriately performed in an outpatient setting according to the current standards of care, when there are no serious complications requiring inpatient services.
9. The admission of a member whose baseline condition requires the use of complex medical technology, when the admission is primarily due to the need for such technology or other maintenance services related to the pre-existing medical condition(s), unless the member's condition is significantly deteriorating.
10. The admission is primarily for a continuation of treatment or monitoring that has already been delivered effectively in the home, hospital outpatient department, or other institutional setting.
11. The admission of a member who is a patient or resident in another institutional setting, and is admitted primarily for diagnostic or treatment services that could have been provided in the member's current institutional setting or by using outpatient services.
12. The admission of a member who has simple, uncomplicated, outpatient surgery and is being admitted primarily because of the time of day or the need for postoperative observation.

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13. The admission is primarily due to the:

- amount of time a member has spent as an outpatient in a hospital or other outpatient setting;
- time of day a member recovers from outpatient surgery;
- need for education of the member, parent, or primary caretaker;
- need for diagnostic testing or obtaining consultations;
- need to obtain medical devices or equipment or arrange home care or other noninstitutional services;
- age of the member;
- convenience of the physician, hospital, member, family, or other medical provider;
- type of unit within the hospital in which the member is placed; or
- need for respite care.

D. Observation Services

[excerpted from the Division's outpatient hospital regulations at 130 CMR 410.414]

Reimbursable Services. The Division covers medically necessary observation services provided by acute inpatient hospitals. Reimbursable observation services may exceed 24 hours, and do not need to be provided in a distinct observation unit. To qualify for reimbursement of observation services, the medical record must specifically document when those services began and ended, the purpose of observation, and the name of the physician who ordered it. Acute inpatient hospitals will be reimbursed for these observation services on an outpatient basis in accordance with the signed provider agreement with the Division.

Nonreimbursable Services.

- (1) Nonreimbursable observation services include but are not limited to:
 - (a) services that are not reasonable or necessary for the diagnosis or treatment of the member; and
 - (b) routine preparation and recovery services associated with diagnostic testing or outpatient surgery.
- (2) The following services are not reimbursable as a separate service:
 - (a) postoperative monitoring during a standard recovery period that should be characterized as recovery-room services; and
 - (b) observation services provided concurrently with therapeutic services such as chemotherapy.

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Acute Inpatient Hospital Admission Guidelines

A. Introduction

This appendix is intended to help providers make appropriate decisions about the medical necessity of acute inpatient hospital admissions. These guidelines have been approved by physicians from several medical specialties who have active practices in Massachusetts. Providers making decisions on whether to admit a member as an inpatient should use their medical judgment and these guidelines. Services that meet medical-necessity criteria at 130 CMR 450.204 and the rules governing reimbursement of inpatient, outpatient, and observation services in 130 CMR 410.414 (see section D of this appendix) and 415.414 are reimbursable by the Division.

B. Definitions for Inpatient, Observation, and Outpatient Services

The reimbursability of services defined below is not determined by these definitions, but by application of the Division's regulations in 130 CMR 410.000, 415.000, and 450.000.

Inpatient Services — medical services provided to a member admitted to an acute inpatient hospital.

Observation Services — outpatient hospital services provided anywhere in an acute inpatient hospital, to evaluate a member's condition and determine the need for admission to an acute inpatient hospital. Observation services are provided under the order of a physician, consist of the use of a bed and intermittent monitoring by professional licensed clinical staff, and may be provided for more than 24 hours.

Outpatient Hospital Services — medical services provided to a member in a hospital outpatient department. Such services include, but are not limited to, emergency services, primary-care services, observation services, ancillary services, day-surgery services, and recovery-room services.

Outpatient Services — medical services provided to a member in an outpatient setting including but not limited to hospital outpatient departments, hospital-licensed health centers, physicians' offices, nurse practitioners' offices, freestanding ambulatory surgery centers, day treatment centers, or the member's home.

C. Admission Guidelines

The following guidelines describe admissions that generally are not medically necessary. This is not an all-inclusive list. The Division or its agent may also determine that other admissions not characterized in this list are medically unnecessary and nonreimbursable on an inpatient basis.

1. The admission occurs following observation services, and the admitting provider has not documented at least one of the following in the medical record at the time the decision to admit is made:
 - Failure to respond to outpatient treatment and a clear deterioration of the patient's clinical status;
 - a significant probability that the treatment plan will continue to need frequent clinical modifications and what specific modifications are necessary;
 - instability of the patient that is a deviation from either normal clinical parameters or the patient's baseline; or
 - a requirement for more intensive services than were already being delivered while the patient was on observation status, and a physician's order for each specific new service.

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Exhibit 3:
C. 147 of the Acts and Resolves of 1995

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Chapter 147
Boston Public Health Act of 1995

AN ACT RELATIVE TO PUBLIC HEALTH IN THE CITY OF BOSTON.

Be it enacted by the Senate and House of Representatives in General Court assembled, and by the authority of the same, as follows:

Spec L
c. 570
§ 1

SECTION 1. (a) It is hereby declared for the benefit of the people of the city of Boston, in order that there be an increase in their welfare and an improvement in their living conditions, it is essential that a new public health care system be established for the city of Boston that can meet the challenges of a rapidly changing health care environment and ensure the continuous delivery of quality health care to the residents of the city; that the new public health care system must be able to coordinate outreach, health education, prevention, outpatient, home care, emergency, inpatient, specialty, aftercare, rehabilitation, and long term care services in order to create a comprehensive and integrated continuum of care with the goal of promoting health and well-being, meeting the medical and public health needs of all served and of educating future physicians and caregivers; that a new public health commission be created in the city of Boston as the successor to the city's department of health and hospitals in order to better administer, enhance and expand the public health services provided by the city; and that the city's new public health care system should consist of a network of health care providers joining the city's traditional public health services and facilities with private hospitals, community health centers and other associated community based organizations and providers.

(b) It is hereby further declared for the benefit of the people of the city of Boston that the city should be empowered to provide for the establishment of a new medical center as the centerpiece of the city's public health network to be composed of Boston City Hospital, Boston Specialty and Rehabilitation Hospital and a private, nonprofit hospital; that the mission of the new medical center, in partnership with the city's public health commission, community health centers and other community based providers, shall be to consistently provide excellent and accessible health care services to all in need

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Spec L
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§ 1

of care, regardless of status or ability to pay, that recognizing the historic mission and commitment of Boston City Hospital to the public health needs of all residents of Boston, the new medical center shall have a continued commitment to the urban population, to vulnerable populations within the city, including those residents of the city who are underserved by existing health care services, and to other communities served; that the new medical center shall play an important role as a referral, tertiary level hospital serving the region in a financially responsible manner and continue to serve the most acutely ill patient populations; and that in the conduct of this mission, the new medical center shall commit itself to six equally important guiding principles: (1) ensuring the availability of a full range of primary through tertiary medical programs, in addition to a commitment to public health, preventive, emergency and long term rehabilitative care programs; (2) serving both urban and suburban communities in a culturally and linguistically competent manner that strives to meet the current and changing health care needs of people of all races, languages, cultures and economic classes; (3) providing a high degree of medical, nursing, management and technical competency and accountability; (4) enhancing its role as a major academic medical center, including support for bio-medical, public health, medical education and basic science research; (5) providing managed care services to the communities served by the new medical center and participating effectively and competitively in managed care plans serving the patient population; and (6) treating its patients, staff and the communities served with respect and dignity.

This act may be referred to and cited as the Boston Public Health Act of 1995.

SECTION 2. As used in this act the following words shall, unless the context otherwise requires, have the following meanings:-

"Board of health and hospitals", the board of health and hospitals of the city established pursuant to chapter six hundred and fifty-six of the acts of nineteen hundred and sixty-five.

"Boston City Hospital", the hospital located in the city provided for by chapter one hundred and thirteen of the acts of eighteen hundred and fifty-eight under the care and control of the department of health and hospitals, and all branches thereof heretofore or hereafter established, and all other

Spec L
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§ 2

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Exhibit 4:
Transfer Matrices

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TRANSFERRING RULES- WITHIN A HOSPITAL
MANAGED CARE RECIPIENT

NON-MANAGED CARE RECIPIENT

FROM: TRANSFERRING UNIT	TO: RECEIVING UNIT		
	MED SURG	** PSYCH	SUB/ABUSE
MH/SA NETWORK HOSPITAL	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY TRANSFERRING UNIT: MH/SA CONTRACT RATE TRANSFER PER DIEM	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH/SA CONTRACT RATE
	** PSYCHIATRIC	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE RECEIVING UNIT: MH/SA CONTRACT RATE TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE RECEIVING UNIT: MH/SA CONTRACT RATE
	SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE RECEIVING UNIT: MH/SA CONTRACT RATE TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE RECEIVING UNIT: MH/SA CONTRACT RATE
DH/SA NETWORK HOSPITAL	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY TRANSFERRING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE
	** PSYCHIATRIC	TRANSFERRING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE	TRANSFERRING & RECEIVING UNITS: TRANSFER PER DIEM RECEIVING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE	TRANSFERRING & RECEIVING UNITS: TRANSFER PER DIEM RECEIVING UNIT: TRANSFER PER DIEM NOT REIMBURSABLE

FROM: TRANSFERRING UNIT	TO: RECEIVING UNIT		
	MED SURG	** PSYCH	SUB/ABUSE
NON-NETWORK HOSPITAL	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY TRANSFERRING UNIT: TRANSFER PER DIEM PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY RECEIVING UNIT: TRANSFER PER DIEM PSYCH PER DIEM
	** PSYCHIATRIC	TRANSFERRING & RECEIVING UNITS: TRANSFER PER DIEM RECEIVING UNIT: TRANSFER PER DIEM PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: TRANSFER PER DIEM RECEIVING UNIT: TRANSFER PER DIEM PSYCH PER DIEM
	SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY RECEIVING UNIT: TRANSFER PER DIEM PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY RECEIVING UNIT: TRANSFER PER DIEM PSYCH PER DIEM

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IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH/SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

IN CASES INVOLVING A TRANSFER TO OR FROM A DH/SA REPLACEMENT UNIT, SUBSTITUTE THE DH/SA CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DH/SA RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

TRANSFERRING RULES- WITHIN A HOSPITAL
MANAGED CARE RECIPIENT

NON-MANAGED CARE RECIPIENT

TO: RECEIVING UNIT				
FROM: TRANSFERRING UNIT		MED SURG	** PSYCH	SUB/ABUSE
MH/SA NETWORK HOSPITAL	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH/SA CONTRACT RATE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: MH/SA CONTRACT RATE
	** PSYCHIATRIC	TRANSFERRING UNIT: MH/SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: MH/SA CONTRACT RATE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE	TRANSFERRING & RECEIVING UNITS: MH/SA CONTRACT RATE
DMH/SA NETWORK HOSPITAL	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: NOT REIMBURSABLE
	** PSYCHIATRIC	TRANSFERRING UNIT: NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE
	SUBSTANCE ABUSE	TRANSFERRING UNIT: NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE	TRANSFERRING & RECEIVING UNITS: NOT REIMBURSABLE

		MED SURG	** PSYCH	SUB/ABUSE
	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
	** PSYCHIATRIC	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
	SUBSTANCE ABUSE	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
	MED/SURG	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY	TRANSFERRING UNIT: TRANSFER PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY
	** PSYCHIATRIC	TRANSFERRING UNIT: NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: PSYCH PER DIEM	TRANSFERRING UNIT: PSYCH PER DIEM RECEIVING UNIT: TRANSFER PER DIEM
	SUBSTANCE ABUSE	TRANSFERRING UNIT: NOT REIMBURSABLE RECEIVING UNIT: TRANSFER PER DIEM	TRANSFERRING & RECEIVING UNITS: TRANS PER DIEM RECEIVING UNIT: PSYCH PER DIEM	TRANSFERRING & RECEIVING UNITS: 1 SPAD ONLY

IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CHR 450.125, AND SHALL BE REIMBURSED BY THE DIVISION'S MH/SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHERE APPROPRIATE. A DMH RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS WITHIN A HOSPITAL SHALL APPLY.

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**TRANSFERRING RULES- BETWEEN TWO HOSPITALS
FOR NON-MANAGED CARE RECIPIENTS ONLY**

MH\SA NETWORK
OR NON-MH\SA
NETWORK HOSPITAL

TO : RECEIVING HOSPITAL	MH\SA NETWORK OR NON-MH\SA NETWORK HOSPITAL		
	MED SURG	** PSYCH	SUB\ABUSE
FROM : TRANSFERRING HOSPITAL	MED\SURG	TRANSFERRING HOSP:	TRANSFERRING HOSP:
		TRANSFER PER DIEM	TRANSFER PER DIEM
		RECEIVING HOSP:	RECEIVING HOSP:
		SPAD	SPAD
MH\SA NETWORK NON-MH\SA NETWORK HOSPITAL	** PSYCHIATRIC	TRANSFERRING HOSP:	TRANSFERRING HOSP:
		PSYCH PER DIEM	PSYCH PER DIEM
		RECEIVING HOSP:	RECEIVING HOSP:
		SPAD	SPAD
	SUBSTANCE ABUSE	TRANSFERRING HOSP:	TRANSFERRING HOSP:
		TRANSFER PER DIEM	TRANSFER PER DIEM
		RECEIVING HOSP:	RECEIVING HOSP:
		SPAD	SPAD

IN CASES OF AN EMERGENCY ADMISSION OF A MANAGED CARE RECIPIENT IN A NON-NETWORK HOSPITAL, THE HOSPITAL MUST FOLLOW AUTHORIZATION PROCEDURES OUTLINED IN 106 CMR 450.125, SHALL BE REIMBURSED BY THE DIVISION'S MH\SA PROVIDER AT THE CURRENT ACUTE HOSPITAL RFA RATE FOR PSYCHIATRIC AND SUBSTANCE ABUSE SERVICES.

IN CASES INVOLVING A TRANSFER TO OR FROM A DMH REPLACEMENT UNIT, SUBSTITUTE THE DMH CONTRACT RATE IN THE ABOVE MATRIX WHEN APPROPRIATE. A DMH RATE CAN APPLY IN CIRCUMSTANCES WHERE THE MATRIX INDICATES THE SERVICE IS NOT REIMBURSABLE. ALL OTHER RULES RELATED TO TRANSFERS BETWEEN TWO HOSPITALS SHALL APPLY.

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Exhibit 5:
114.1 CMR 36.05(3)

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36.05: continued

(h) Payments for newly eligible recipients or in the event of exhaustion of other insurance. When a patient becomes newly Medicaid eligible or if they become eligible because other insurance benefits have been exhausted after the date of admission and prior to the date of discharge, the acute stay is paid using the transfer *per diem* payment, established according to 114.1 CMR 36.05(4), up to the hospital-specific per discharge amount. If the patient is at administrative day status (AD), payment will be made at the AD *per diem*, as established in 114.1 CMR 36.05(5).

(i) Rate of payment for physician services. For physician services provided by hospital-based physicians to Medicaid inpatients, the hospital is reimbursed in accordance with, and subject to, the Physician Regulations at 130 CMR 433.000 *et seq.* Such reimbursement is at the lower of the fee in the most current promulgation of the Division of Health Care Finance and Policy fees as established in 114.3 CMR 16.00, 17.00, 18.00 and 20.00, or the hospital's usual and customary charge.

Hospitals are reimbursed for such physician services only if the hospital-based physician took an active patient care role, as opposed to a supervisory role, in providing the inpatient service(s) on the billed date(s) of service. Physician services provided by residents and interns are reimbursed through the DME portion of the SPAD, and, as such, are not reimbursable separately.

Hospitals are not reimbursed for inpatient physician services provided by community-based physicians.

(j) Rates of payment for Inpatient Hospital Services Provided to Medicaid Recipients Enrolled in Managed Care Organizations (MCOs).

1. The methodology described in 114.1 CMR 36.05 applies to rates for Medicaid recipients enrolled in Managed Care Organizations (MCOs) with the exception of the following.

a. A separate casemix index is calculated for disabled recipients and applied to the statewide standard payment amount per discharge. This results in a distinct and separate per discharge rate, outlier rate and transfer rate which applies to disabled recipients enrolled in MCOs. Disabled recipients enrolled in the Medicaid program are defined as those recipients eligible under S.S.I. and Medicaid Disability Assistance (categories of assistance 03 and 07).

b. A separate casemix index is calculated for non-disabled recipients (all other categories of assistance) and applied to the statewide standard payment amount. This results in a distinct and separate per discharge rate, outlier rate and transfer rate which applies to all Medicaid recipients enrolled in MCOs, except disabled recipients.

2. If an MCO offers to pay a hospital a rate equivalent to the applicable rate of payment established for that hospital by 114.1 CMR 36.05 for services to the MCO's Medicaid enrollees, that hospital is required to accept the MCO's rate offer as payment in full for those enrollees. This requirement does not preclude an MCO from choosing to pay any hospital at a rate higher or lower than the applicable rate of payment established for that hospital by 114.1 CMR 36.05 for services to the MCO's Medicaid enrollees.

(k) Maternity/Newborn Rates Delivery related maternity cases are paid on the standard payment amount per discharge (SPAD) basis with one SPAD paid for the mother and one SPAD paid for the newborn. The rate includes payment for all services except physician services provided in conjunction with a maternity stay, including but not limited to follow-up home visits provided as incentives for short delivery stays. There are no additional payments to the hospitals or to other entities, such as Visiting Nurse Associations or home health agencies, for providing services in collaboration with the hospital. Hospitals are required to apply any and all maternity and newborn policies and programs equally to all patients, regardless of payer.

(3) Outlier Rates of Payments.

(a) Eligibility. An outlier *per diem* payment is added to the standard payment amount per discharge for a particular patient if all of the following conditions are met:

1. the length of stay exceeds 20 cumulative acute days (not including days in a distinct part psychiatric unit);
2. the hospital has fulfilled its discharge planning duties as required by 130 CMR (Division of Medical Assistance regulations);

36.05: continued

3. the patient continues to need acute level care and is therefore not on administrative day status on any day for which outlier payment is claimed;
4. the patient is not a patient in a distinct part psychiatric unit on any day for which an outlier payment is claimed.

(b) The outlier per diem payment amount. To derive the RY00 standard payment amount per day, the statewide average payment amount per discharge was divided by the average FY95 all-payer length of stay of 5.0931. The hospital-specific capital, direct medical education, and pass-thru per diems were derived by dividing the per discharge amount for each of these components by the hospital's MassHealth length of stay. The outlier per diem payment is equal to fifty-five percent of the statewide average payment amount per day multiplied by the hospital's wage area index and casemix index, plus a per diem payment for the hospital's pass through costs, direct medical education, and capital payment amounts.

(c) Pediatric Outlier Payment. In accordance with 42 U.S.C. 1396a(s), an annual pediatric outlier adjustment is made to acute care hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for children greater than one year of age and less than six years of age. Only hospitals that meet the Basic Federally-Mandated Disproportionate Share eligibility per 114.1 CMR 36.07(3) are eligible for the pediatric outlier payment. The Pediatric Outlier Payment is calculated using the data and methodology as follows:

1. Data Source. The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. Eligibility is determined by the Division as follows:

- a. Exceptionally long lengths of stay. First, calculate a statewide weighted average Medicaid inpatient length of stay. This is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. Second, calculate the statewide weighted standard deviation for Medicaid inpatient length of stay. Third, multiply the statewide weighted standard deviation for Medicaid inpatient length of stay by two and add that amount to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold Medicaid exceptionally long length of stay.

- b. Exceptionally high cost. Exceptionally high cost is calculated for hospitals providing services to children greater than one year of age and less than six years of age by the Division as follows:

- i. First, calculate the average cost per Medicaid inpatient discharge for each hospital.

- ii. Second, calculate the standard deviation for the cost per Medicaid inpatient discharge for each hospital.

- iii. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two and add to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

- c. Eligibility for a Pediatric Outlier Payment. For hospitals providing services to children greater than one year of age and under six years of age, the Division calculates the following:

- i. the average Medicaid inpatient length of stay involving children greater than one year of age and less than six years of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.a., then the hospital is eligible for a Pediatric Outlier Payment.

- ii. the cost per inpatient Medicaid case involving children greater than one year of age and less than six years of age. If this hospital-specific Medicaid inpatient cost equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(c)2.b., then the hospital is eligible for a Pediatric Outlier Payment.

- iii. Payment to Hospitals. Hospitals qualifying for an outlier adjustment in the payment amount pursuant to 114.1 CMR 36.05, receive 1/2% of the total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e). The total funds allocated for payment to acute hospitals under 114.1 CMR 36.07(3)(e) are reduced by the payment amount under 114.1 CMR 36.05(3)(c).

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(d) **Infant Outlier Payment** In accordance with 42 U.S.C. 1396a(s), an annual infant outlier payment adjustment is made to hospitals providing medically necessary inpatient hospital services involving exceptionally high costs or exceptionally long lengths of stay for infants under one year of age. The Infant Outlier Payment is calculated using the data and methodology as follows:

1. **Data Source.** The prior year's claims data residing on the Division of Medical Assistance Massachusetts Medicaid Information System is used to determine exceptionally high costs and exceptionally long lengths of stay.

2. **Eligibility** is determined by the Division as follows:

a. **Exceptionally Long Lengths of Stay:** The statewide weighted average Medicaid inpatient length of stay is determined by dividing the sum of Medicaid days for all acute care hospitals in the state by the sum of total discharges for all acute care hospitals in the state. The statewide weighted standard deviation for Medicaid inpatient length of stay is also calculated.

The statewide weighted standard deviation for the Medicaid inpatient length of stay is multiplied by two, and added to the statewide weighted average Medicaid inpatient length of stay. The sum of these two numbers is the threshold figure for Medicaid exceptionally long length of stay.

b. **Exceptionally High Cost** is calculated for hospitals providing services to infants under one year of age by the Division as follows:

i. First, the average cost per Medicaid inpatient case for each hospital is calculated;

ii. Second, the standard deviation for the cost per Medicaid inpatient case for each hospital is calculated;

iii. Third, multiply the hospital's standard deviation for the cost per Medicaid inpatient discharge by two, and add that amount to the hospital's average cost per Medicaid inpatient discharge. The sum of these two numbers is each hospital's threshold Medicaid exceptionally high cost.

c. For each hospital providing services to infants under one year of age, the Division determines first, the average Medicaid inpatient length of stay involving individuals under one year of age. If this hospital-specific average Medicaid inpatient length of stay equals or exceeds the threshold defined in 114.1 CMR 36.05(3)(d)2.a., then the hospital is eligible for an infant outlier payment.

Second, the cost per inpatient Medicaid case involving infants under one year of age is calculated. If a hospital has a Medicaid inpatient case with a cost which equals or exceeds the hospital's own threshold defined in 114.1 CMR 36.05(3)(d)2.b. above, then the hospital is eligible for an infant outlier payment.

d. **Payment to Hospitals.** Annually, each hospital that qualifies for an outlier adjustment receives an equal portion of \$50,000. For example, if two hospitals qualify for an outlier adjustment, each receives \$25,000.

(4) **Rates of Payments for Transfer Patients.** The text and matrices contained in 114.1 CMR 36.05(4) set forth the payment rates applicable to transferred patients.

(a) **Transfers between hospitals.**

1. In general, payments for patients transferred from one acute hospital to another will be made on a transfer *per diem* basis, capped at the per discharge payment amount, for the hospital that is transferring the patient.

2. The transfer *per diem* payment amount is equal to the statewide standard payment amount per day, multiplied by the transferring hospital's Medicaid casemix index derived from paid claims between June 1, 1998 and May 31, 1999 and wage area index, plus pass-through, direct medical education, and capital *per diem* payments. The standard payment amount per day is derived by dividing the statewide standard payment amount per discharge by the FY95 average all-payer length of stay. The hospital-specific capital, direct medical education and pass-through per diem payments are derived by dividing the per discharge amount for each of these components by the hospital's Medicaid length of stay from casemix data.

3. In general, the hospital that is receiving the patient will be paid on a per discharge basis, in accordance with the methodology specified in 114.1 CMR 36.05(2), if the patient is actually discharged from that hospital. If the patient is transferred to another hospital, then the transferring hospital is paid at the hospital specific transfer *per diem* rate up to the hospital specific per discharge amount. Additionally, "back transferring" hospitals are eligible for outlier payments specified in 114.1 CMR 36.05(3).

TN 99-12
STATE PLAN AMENDMENT EXHIBITS
INPATIENT ACUTE HOSPITAL

Exhibit 6:
114.1 CMR 36.07
114.6 CMR 11.00

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36.07: Disproportionate Share Payment Adjustments**(1) Overview.**

(a) **Applicability.** The Medicaid program assists hospitals that carry a disproportionate financial burden of caring for the uninsured and publicly insured persons of the Commonwealth. In accordance with Title XIX rules and requirements, Medicaid makes an additional payment adjustment above the rates established under 114.1 CMR 36.05 and 114.1 CMR 36.06 to hospitals which qualify for such an adjustment under any one or more of the following classifications. Medicaid payment adjustments for disproportionate share hospitals are a source of funding for allowable uncompensated care costs.

(b) **Eligibility.** Only hospitals that have an executed contract with the Division of Medical Assistance are eligible for disproportionate share payments. Medicaid participating hospitals may qualify for adjustments and may receive them at any time throughout the year. Eligibility requirements for each type of disproportionate share adjustment and the methodology for calculating those adjustments are described in 114.1 CMR 36.07. When hospitals apply to participate in the Medicaid program, their eligibility and the amount of their adjustment is determined. As new hospitals apply to become Medicaid providers, they may qualify for adjustments if they meet the criteria under one or more of the following disproportionate share hospital (DSH) classifications (114.1 CMR 36.07). If a hospital's Medicaid contract is terminated, any adjustment is prorated for the portion of the year during which it had a contract, the remaining funds it would have received are apportioned to remaining eligible hospitals. This means that some disproportionate share adjustments may require recalculation. Hospitals are informed if an adjustment amount changes due to reapportionment among the qualified group and told how overpayments or underpayments by the Division of Medical Assistance are handled at that time. To qualify for a DSH payment adjustment under any classification within 114.1 CMR 36.07, a hospital must meet the obstetrical staffing requirements described in Title XIX at 42 U.S.C. § 1396r-4(d) or qualify for the exemption described at 42 U.S.C. § 1396r-4(d)(2). In addition, to qualify for a disproportionate share payment adjustment under 114.1 CMR 36.07 a hospital must have a Medicaid inpatient utilization rate, calculated by dividing Medicaid patient days by total days, of not less than 1%. Effective October 1, 1995 the total amount of DSH payment adjustments awarded to a particular hospital under 114.1 CMR 36.07 cannot exceed the costs incurred during the year by the hospital for furnishing hospital services to individuals who are either eligible for medical assistance or have no health insurance or other source of third party coverage less payments received by the hospital for medical assistance and from uninsured patients, and as provided at 42 U.S.C. § 1396r-4(g).

(2) High Public Payer Hospital Disproportionate Share Adjustment.

(a) **Eligibility.** Hospitals determined eligible for disproportionate share status pursuant to 114.1 CMR 36.04 are eligible for this adjustment.

(b) Calculation of Adjustment.

1. The Division of Medical Assistance allocates \$11.7 million for this payment adjustment.
2. The Division then calculates for each eligible hospital the ratio of its allowable free care charges, as defined in M.G.L. c. 118G, to total charges. The Division will obtain free care charge data from the hospitals UC-Form filings, on a fiscal year basis consistent with the data cited in 114.1 CMR 36.04(2)(a).
3. The Division then ranks the eligible hospitals from highest to lowest by the ratios of allowable free care to total charges determined in 114.1 CMR 36.07(2)(b)2.
4. The Division then determines the 75th percentile of the ratios determined in 114.1 CMR 36.07(2)(b)2.
5. Hospitals who meet or exceed the 75th percentile qualify for a High Public Payer Hospital Adjustment. The Division multiplies each qualifying hospital's allowable free care charges by the hospital's most recent cost to charge ratio, as calculated pursuant to 114.6 CMR 11.04 to determine allowable free care costs.
6. The Division then determines the sum of the amounts determined in 114.1 CMR 36.07(2)(b)5. for all hospitals that qualify for a High Public Payer adjustment.
7. Each eligible hospital's High Public Payer Hospitals adjustment is equal the amount allocated in 114.1 CMR 36.07(2)(b)1. multiplied by the amount determined in 114.1 CMR 36.07(2)(b)5. and divided by the amount determined in 114.1 CMR 36.07(2)(b)6.